CDC BOTULISM ANTITOXIN RELEASE AND REACTION REPORT

To be filled out by releasing physician in its entirety and returned to Botulism surveillance officer immediately after antitoxin release and reaction information obtained.

Person Releasing Antitoxin _____ Today's Date _____ ***(mm/dd/yyyy)***

Date of Antitoxin Release _____ ***(mm/dd/yyyy)*** Quarantine Station _____

Is this release outbreak related? YES NO DK

If re-release, reason _____

Patient(s) ***Patient #1 should be index case, please complete a separate form for each additional patient) (last name, first name)***

1.) _____ age _____ sex _____

2.) _____ age _____ sex _____

3.) _____ age _____ sex _____

4.) _____ age _____ sex _____

(Continue on back if necessary)

Treating Physician _____ Phone _____ Fax _____
(last name, first name) **(Required)**

Pager _____ E-mail _____

Attending Physician _____ Phone _____ Fax _____
(last name, first name) **(Required)**

Pager _____ E-mail _____

Hospital Name _____

Street Address _____

City _____ State _____ Zip _____

Other contacts/consultants:	Specialty:	Phone:	Fax:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

State health department contact:

Name _____ Phone _____

Email _____ Fax _____

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INFORMATION REGARDING CASE NUMBER ____
(use additional forms if more than one case)

Antitoxin Release:

1. Preliminary History: ***(please use mm/dd/yyyy format.)***

A. Date first call received at branch ____/____ /_____

B. Onset date of symptoms ____/____ /_____

C. Date first seen by physician ____/____ /_____

D. Was patient hospitalized? YES NO DK

a. Date hospitalized ____/____ /_____

b. Was patient admitted to intensive care? YES NO DK

If yes: date admitted: ____/____ /_____

c. Was patient placed on a ventilator? YES NO DK

If yes: date intubated: ____/____ /_____

E. Did patient die? YES NO DK

If yes:

a. Date of death: ____/____ /_____

b. Cause of death: _____

2. Recent Medication History: ***(please circle the correct answer)***

A. Was the patient on any of the following medications in the thirty (30) days prior to onset?

a. phenothiazine YES NO DK

b. aminoglycoside YES NO DK

c. anticholinergic YES NO DK

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3. Clinical History:

A. Describe general symptom progression _____
_____
_____
_____
_____
_____

B. **Symptom History:** ***(Please circle appropriate answer)***

Abdominal pain	YES	NO	DK
Nausea	YES	NO	DK
Vomiting	YES	NO	DK
Diarrhea	YES	NO	DK
Blurred vision	YES	NO	DK
Diplopia	YES	NO	DK
Dizziness	YES	NO	DK
Slurred speech	YES	NO	DK
"Thick tongue"	YES	NO	DK
Change in sound of voice	YES	NO	DK
Hoarseness	YES	NO	DK
Dry mouth	YES	NO	DK
Difficulty swallowing	YES	NO	DK
Shortness of breath	YES	NO	DK
Subjective weakness	YES	NO	DK
Fatigue	YES	NO	DK
Paresthesia	YES	NO	DK
Site: _____			
Wound	YES	NO	DK
Describe: _____			

C. **Physical Exam Findings:**

Altered mental state	YES	NO	DK	
Extraocular palsy	YES	BILATERAL	NO	DK
Ptosis	YES	BILATERAL	NO	DK
Pupils dilated	YES	BILATERAL	NO	DK
Pupils constricted	YES	BILATERAL	NO	DK
Pupils fixed	YES	BILATERAL	NO	DK
Pupils reactive	YES	BILATERAL	NO	DK
Facial paralysis	YES	BILATERAL	NO	DK
Palatal weakness	YES	BILATERAL	NO	DK
Impaired gag reflex	YES	BILATERAL	NO	DK
Sensory deficit(s)	YES	NO	DK	
Describe _____				

D. Vital Signs: ***(upon presentation)***

Temperature (°F) _____ Blood Pressure ____/____ Heart Rate _____ Resp. Rate _____

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E. Deep tendon reflexes:

Abnormal deep tendon reflexes	YES	NO	DK
Biceps/Triceps	YES	NO	DK
Brachial	YES	NO	DK
Patellar	YES	NO	DK
Ankle	YES	NO	DK

Describe _____

F. Weakness/paralysis: Please indicate if weakness or paralysis was noted in the patient before the antitoxin was released. ***(Please circle appropriate answer)***

a. Upper extremities

If yes:

i. Upper distal	YES	BILATERAL	NO	DK
ii. Upper proximal	YES	BILATERAL	NO	DK

b. Lower extremities

If yes:

i. Lower distal	YES	BILATERAL	NO	DK
ii. Lower proximal	YES	BILATERAL	NO	DK

c. Describe weakness/paralysis:

If yes:

i. Ascending (beginning in lower extremities, progressing to upper extremities, then cranial nerves)

YES BILATERAL NO DK

ii. Descending (beginning with cranial nerves, progressing to upper extremities, then (in some cases) to lower extremities.

YES BILATERAL NO DK

d. Comments _____
_____
_____
_____

4. Laboratory Results: ***Please list the laboratory results which were available <u>before the antitoxin was released</u>.***

A. Was a lumbar puncture done? YES NO DK

If yes:

1. Lumbar puncture 1:
   a. Date done: ___/___/ _____ ***(mm/dd/yyyy format)***
   b. RBC: _____
   c. WBC: _____
   d. Protein: _____
   e. Glucose: _____

2. Was repeat lumbar puncture done? YES NO DK

If yes:

a. Date done: ___/___/ _____ ***(mm/dd/yyyy format)***
b. RBC: _____
c. WBC: _____
d. Protein: _____
e. Glucose: _____

B. Was a tensilon test (Edrophonium chloride) done? YES NO DK

If yes:

a. Date done: ___/___/ _____ ***(mm/dd/yyyy format)***
b. Results: _____

C. Was electromyography (EMG) done? YES NO DK

If yes:

a. Date done: ___/___/ _____ ***(mm/dd/yyyy format)***
b. Muscle group: _____
c. Nerve conduction results: _____
d. Was Rapid repetitive stimulation conducted? YES NO DK

If yes:

1. Hertz: _____
2. Result: _____

D. Was brain imaging done? YES NO DK

If yes:

a. Was a CT done? YES NO DK

If yes:

1. Date done: ___/___/ _____ ***(mm/dd/yyyy format)***
2. Findings: _____

b. Was a MRI done? YES NO DK

If yes:

1. Date done: ___/___/ _____ ***(mm/dd/yyyy format)***
2. Findings: _____

5. Differential Diagnosis by Clinician:

A.) _____
B.) _____
C.) _____

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6. Pertinent Patient History: Please list pertinent patient. ***(circle appropriate answer)***

A. Did the patient consume home-canned food? YES NO DK

If yes:

a. Type of food:_____

b. Are samples available for testing? YES NO DK

B. Did the patient have a wound or trauma? YES NO DK

If yes:

a. Type of wound/trauma:_____

b. Are samples available for testing? YES NO DK

C. Is the patient an IV drug user? YES NO DK

If yes:

a. Type of drug use:_____

b. Are samples available for testing? YES NO DK

7. Comments:

_____

_____

_____

_____

8. Type of Botulism: Wound Foodborne Adult Intestinal Unknown Other (specify):_____

Follow up Instructions:

WITHIN 48 HOURS OF ANTITOXIN RELEASE

FDDB staff member: Please follow up with treating physician to complete antitoxin reaction section of this questionnaire (Pages 6 and 7). Once completed, please return this form to the botulism surveillance officer for inclusion in the antitoxin release surveillance system.

Also, please remind treating physician of form 2, to be filled out upon patient's discharge from medical treatment. This is a requirement for dispensing antitoxin!

Thank you.

Antitoxin Reactions:

8. Sensitivity Testing: ***(circle the appropriate answer)***

A. Was sensitivity testing done prior to antitoxin administration? YES NO DK

If yes:

a. What was the site of sensitivity testing (i.e. skin, eye)? _____

b. What was the route of sensitivity testing? ***(please circle route used for testing)***

Intradermal SQ Other specify other: _____

c. What dosage was used for sensitivity testing? _____ units _____

d. What diluent was used for sensitivity testing? _____

9. Antitoxin Administration:

A. Please describe antitoxin administration:

	Lot #	# of vials given	Date ***(mm/dd/yyyy)***	Time (military)
1.	_____	_____	_____	____:____
2.	_____	_____	_____	____:____

10. Antitoxin Reactions: ***(Please circle appropriate answer: For each "yes" answer, please indicate how soon the reaction began after the start of the antitoxin treatment, and how long the reaction lasted. Do not include reactions during sensitivity testing)***

A. Fever: YES NO DK

If yes:

a. How soon after administration (hours)? _____hrs

b. How long did reaction last (hours)? _____hrs

B. Chills/Rigors: YES NO DK

If yes:

a. How soon after administration (hours)? _____hrs

b. How long did reaction last (hours)? _____hrs

C. Rash: YES NO DK

If yes:

a. How soon after administration (hours)? _____hrs

b. How long did reaction last (hours)? _____hrs

c. Describe rash: _____

D. Urticaria: YES NO DK

If yes:

a. How soon after administration (hours)? _____hrs

b. How long did reaction last (hours)? _____hrs

c. Describe urticaria: _____

E. Swelling/edema: YES NO DK

If yes:

a. How soon after administration (hours)? _____hrs

b. How long did reaction last (hours)? _____hrs

c. Describe swelling/edema: _____

10. Antitoxin Reactions (cont.)

F. Other hypersensitivity: YES NO DK

If yes:

a. How soon after administration (hours)? _____hrs
b. How long did reaction last (hours)? _____hrs
c. Describe hypersensitivity: _____

G. Anaphylaxis: YES NO DK

If yes:

a. How soon after administration (hours)? _____hrs
b. How long did reaction last (hours)? _____hrs
c. Describe anaphylaxis: _____

H. Serum sickness: YES NO DK

If yes:

a. How soon after administration (days)? _____days
b. How long did reaction last (days)? _____days
c. Describe serum sickness: _____

I. Other reactions: YES NO DK

If yes:

a. How soon after administration (hours)? _____hrs
b. How long did reaction last (hours)? _____hrs
c. Describe reaction: _____

J. If the patient received any treatment for a reaction, or antitoxin administration was stopped, please describe _____
_____
_____

Please return this form the botulism surveillance officer in FDDB.

Thank you.